SALZBURG SEMINAR 395

Health

Food Systems and Rural Development

Youth and Education

Philanthropy and Volunteerism

Southern Africa

Latin America and the Caribbean

"We are all caught in an inescapable network of mutuality; tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."

—Martin Luther King, Jr.

Who lives, who dies, what we can do:

Exploding Myths, Finding Solutions To The World's Health Care Crisis

W.K. KELLOGG FOUNDATION

Exploding Myths, Finding Solutions To The World's Health Care Crisis

W.K. KELLOGG FOUNDATION

The Salzburg Seminar was established in 1947 to bring together young intellectuals from nations recently at war to discuss topics of mutual interest. Since that time, more than 23,000 Fellows from 150 countries have participated in more than 400 sessions and symposia. The contacts and friendships made in Salzburg have proven to be of enduring value, and the issues examined, of great significance in the fields of transnational public policy, democracy, education, culture, and the arts.

The W.K. Kellogg Foundation's relationship with the Salzburg Seminar spans more than 30 years. Since the 1990s, a series of partnership sessions have focused on the Foundation's primary areas of concern: Health; Youth and Education; Philanthropy and Volunteerism; and Food Systems and Rural Development. Through its support of the Salzburg Seminars, the Kellogg Foundation links its programming interests in the United States, Latin America and the Caribbean, and southern Africa with other parts of the world, including West, Central, and Eastern Europe; the former Soviet Union; the Middle East; South Asia; and the Far East.

Salzburg Seminar 395

Improving Access to Health Care and Human Services: Elements of Success

March 6-13, 2002

There is universal need for improvement of quality health care and greater access to human services. Although we've seen improvements in areas such as availability of childhood vaccinations and affordable HIV/AIDS treatment drugs, there remain significant obstacles to general health care and preventive primary care.

Diverse and innovative strategies have been implemented around the world to overcome these barriers and to improve access to health services. These include education, greater sensitivity to cultural acceptability, and increased affordability of health care. This session of the Salzburg Seminar included informative presentations and discussions that addressed the critical state of human health worldwide, and reviewed encouraging models of improved health education, disease prevention, health access, and care from South America, Africa, the United States, the Caribbean, and China. It also identified key barriers to new modes of health care access and service for vulnerable populations, strategies for overcoming those barriers, and the universal components of an "ideal" health care system.

Table of Contents

Introduction

Henrie M. Treadwell

In mid-March of 2002, a group of nearly 70 health care professionals gathered in Salzburg, Austria, for a week of intense analysis, debate, and action-oriented thinking about what might be done to improve health care for the world's most vulnerable populations. The participants – known as Salzburg Fellows – were a professionally and globally diverse group. They included a researcher/medical obstetrician from Peru, a health project coordinator from Armenia, a senior attorney general from the U.S. (New Hampshire), a pediatric neurologist from Russia, a community health worker from South Africa, the dean of one of the United States' major medical and research universities, a biomedical engineering professor from Lithuania, the public health dean from a Chinese university, a clinical pathologist from Pakistan, and a health statistician from the World Health Organization.

"We don't go by job titles or educational degrees. There are no 'country delegations.' We want you to leave that baggage at the Salzburg door."

– Henrie Treadwell

At the opening session, we challenged the group to go beyond just dialogue. We asked the Fellows to look carefully at the critical state of health care services for the poor worldwide – the health, social, and economic dimensions. They were to move beyond identifying and stating problems and needs.

We believe the Fellows have not only identified the signposts, but also moved us down the road toward confronting and answering the universal challenges of equality in health care.

The Fellows have taught us that there are equitable, consumer-centered approaches to health services. They have clearly exposed and articulated many of the underlying social factors that influence health. We see how such a "vision" of what might be would involve a complete paradigm shift to a community-based model of care, rather than one based on incremental or sequential steps of improving the current way we care for people.

The Fellows brought home to us, once again, the importance of relationships and coalitions as the basis for change. And they reminded us that the equity of health care for the world's "have-nots" often requires exposing the ugly face of inequality through the news media. We learned that while we come from many countries, health care inequalities are often the same – that there is a global "common ground" for seeking change.

Some of the best, most relevant "lessons learned" during the Seminar were ideas and projects being tried in some of the world's most impoverished countries. And finally, as one Fellow observed near the end of our week together, "Peace has to be an integral part of a healthy society."

Yet, in a way, the week will never end. Thanks to the technology and creativity of the Salzburg Seminar staff, nearly all of the Fellows are part of a special computer "listserv" that gives them near instant capability to reach each other individually, and collectively, in order to continue the dialogue; continue to look at aspects of the "ideal model" they developed; and, perhaps most important, to continue help building a world where health care for all is a right and a reality.

"We are all caught in an inescapable network of mutuality; tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."

– Rev. Martin Luther King, Jr.

As I write this brief introduction, it has been 36 years – to the day – since America's moral voice and singular champion of equality, the Rev. Martin Luther King, Jr., confined at the time in the Birmingham, Alabama, jail protesting racial injustice, penned the famous words found on the cover of this publication:

"We are all caught in an inescapable network of mutuality; tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."

Dr. King's words are even more relevant today. That is the message; the promise; and, it is hoped, the prospect of this effort to create a more equitable health care system.

"Leading social change may take you to a 'lonely place,' but lead anyway."

– Henrie Treadwell

The Health Care Crisis in Vulnerable Populations: Who Lives, Who Dies, and Why

Where do you start developing a more equitable health care system?

For the Salzburg Fellows, the approach over nine intensive days was to move from presentations and discussion focusing on the facts of health care inequalities and crisis worldwide, to examination of successful new models of health policy, education, and care in various national and community settings, to identification of common elements for change. And finally, to "pulling it all together" by illustrating an equitable health care system that reaches across the main variables of economic, social, and political life in countries across the world.

That same order is followed in this publication.

The following sections are more than just edited versions of the presenters' written text and illustrations. They have been carefully compiled from personal interviews with most of the presenters, written texts of the proceedings, and both audio and visual materials used at the sessions.

Putting a Human Face and Social Context on Today's Worldwide Health Crisis

David R. Williams
Professor of Sociology, Institute for Social Research
University of Michigan, Ann Arbor, United States

Williams provided a compelling, factual presentation on the racial and social disadvantages of health care among poor peoples of the world. There is growing recognition that racial differences in economic circumstances are central to understanding racial differences and health. Disparity in economic status between racial and ethnic groups accounts for most, but not all, of the racial/ethnic disparities in health.

Over recent decades, human mortality rates have improved in nearly every country (a notable and profound exception being Russia). As per capita income increases in countries, good health care and its impact on quality of life are also evident. People are living longer. Yet, the relative gap in health care by social and economic class is greater today than in 1940. Worldwide, people of lower economic status are worse off in terms of health. Williams cited the specific example of health disparities in Brazil.

In the United States, the mortality rate for the black population was 1.5 times that of whites in 1998, identical to what it was in 1950. Looking just at infant mortality, in 1950, a black infant was 1.6 times more likely to die before his or her first birthday than a white infant. In 1998, a black infant was 2.4 times more likely to die before his or her first birthday. Racial, religious, and other social stereotypes that are persistent, intractable and largely ignored or disavowed compound this basic reality, Williams said.

> "Could it be that well-intentioned health professionals who are personally opposed to prejudice are, nonetheless, biased in the delivery of care to minority group members? Several hundred research studies suggest this is the case." What this means "is that if you hold negative stereotypes, they are automatically triggered in how you react to, how you treat other people in your daily life."
>
> – David R. Williams

Unconscious Discrimination: A Universal Phenomenon?

As an example, Williams cited the dramatic decline of overt racial prejudice in the United States over recent decades, a "50 to 60 percent positive shift toward 'the principles of equality.'"

Today, less than 10 percent of whites in the United States express overt racial prejudice, according to recent studies. Most Americans, and their government, take great pride in this change. At the same time, this only translates to "an abstract commitment to equality," since less than 20 percent of white Americans hold positive stereotypes of black Americans, he asserted. For example, 44 percent of whites believe that blacks are lazy, 51 percent view them as prone to violence, 29 percent see them as unintelligent, and 56 percent believe that they prefer to live off welfare.

"Could it be that well-intentioned health professionals who are personally opposed to prejudice are, nonetheless, biased in the delivery of care to minority group members? Several hundred research studies suggest this is the case." What this means "is that if you hold negative stereotypes, they are automatically triggered in how you react to, how you treat other people in your daily life."

How has this translated into health care? Williams noted one study that found white Medicare patients were four times more likely than blacks to receive bypass surgery. Another revealed that Mexican Americans with potential heart failure received 38 percent fewer medications than whites. It is likely that unconscious or unthinking discrimination based on negative stereotypes may be responsible for these patterns of systematic bias in delivery of medical care, Williams said.

Ironically, human genome studies have shown that people – regardless of race – are genetically 99.9 percent the same. There are more genetic differences within racial groups than across racial groups. Nonetheless, racial categories reflect part of the economic inequality and historic injustice that continue to afflict society.

Williams said these realities fail to address the real problem, "that as soon as people see themselves as part of a relatively distinct economic or social group, discrimination against those outside the group happens." Across all levels of income, African Americans report poorer health than whites. Such a pattern exists for other health outcomes such as coronary heart disease, mortality, and life expectancy. The data reflects the power of socioeconomic status to shape differences in health. These stereotypes, as well as others held about women, gays, and the elderly, are responsible for maintaining the gap in health care by social class.

According to Williams, the importance of socioeconomic status and social stereotypes on the future of health care cannot be overstated. For example, take the elderly. The predictions are almost cataclysmic: In 50 years, if trends continue, the number of people older than 60 will triple. Those 2 billion seniors will outnumber the world's youth.

By 2150, one-third of the world's population will be older than 60. But long before that, gains in longevity could bring a worldwide economic crisis, Williams warned. With the population's proportion of taxpaying workers shrinking, national budgets may well be overwhelmed in trying to provide retirement and health benefits for the elderly.

In the face of such realities, there is growing interest in developing more effective, more cost-accountable, and culturally sensitive health care services for vulnerable populations, and reducing costs/expenditures across all groups. However, in discussions of cultural sensitivity, little attention is given to fairly routine processes of unconscious and unthinking discrimination. Williams believes there is a pressing need to raise awareness about these phenomena and to identify effective strategies to reduce the likelihood of their occurrence.

Where there are glaring disparities in personal and family income within a society, such as those in South Africa, health care differences are even more profound. In South Africa, whites have a per capita income almost 12 times that of blacks, 5 times that of coloreds, and 2.5 times that of Asians. Compared to the two percent poverty rate of whites, the rate of poverty is 29 times higher for blacks. For all racial groups, the poverty rate is higher for children than the total population in South Africa.

For two striking illustrations of how the social context can shape health outcomes, consider these dramatic statistics from Russia and Eastern Europe. Following the collapse of the Soviet Union in 1991, life expectancy for Russian males declined by six years between 1991 and 1994.

The persons most affected were middle-aged urban males in manual occupations, with the steepest rise in mortality among those with the lowest levels of education. The changes appear to have been driven by increases in chronic illnesses, as well as behaviors that lead to homicide. With the collapse of communism, an overhaul of the Russian economic system led to increased inflation, reduced wages, and greater poverty. All of these forces combined to produce higher levels of crime,

"New approaches on economic development, such as globalization or privatization, are main factors for the worsening of health status. The solution is outside of health care. The solution is to engage politicians in health care."

– Yusuf Celik

social disintegration, and stress, as well as a drop in food consumption, health habits, and living conditions.

Worldwide, considerable evidence suggests that modern medical care plays a limited role as a determinant of health. Medical care accounted for only a small fraction of the improvements in individual and population health evident over the last 250 years. Most improvement was due to increases in socioeconomic development, nutrition, public health, sanitation, and living conditions, Williams said.

Contrary to what might be expected, improvements due to the introduction of national health service plans have had little or no impact on reducing socioeconomic differences in health. For example, in Great Britain, occupational class differences in health are wider today than those prior to implementation of that country's national health service.

"Health is not just a right. It is an economic, social, and human resource that should be nurtured. Healthy people are not only more productive, they also have fewer needs from health and social care systems."

– Barbara Krimgold

What Can We Do in the Face of All These Challenges?

Williams contends we must recognize that health service delivery matters and intervention is possible. He said there is growing evidence that adult health status is affected by current economic conditions, and by exposure to social and economic adversity over the life course. One ominous sign of future social inequalities in health is the relatively high level of child poverty. In some societies, child poverty is very strongly linked to family structure.

However, some countries provide services and protect children from negative effects of economic adversity. The percent of children living with one parent is about the same in Sweden and the United States. Yet only seven percent of Swedish children in single-parent households live in poverty, compared to 55 percent in the United States. In part, these disparities reflect differences in social policy.

Additionally, greater attention should be given to the critical role that interpersonal relations can play in the quality of care provided to individuals. Factors such as empathy, warmth, acceptance, and encouragement account for about 30 percent of improvement observed in psychotherapy. Extra-therapeutic change factors on both the part of the client (such as ego strength) and the environment (such as social support) appear to be responsercent of impible for about 40 provements. Studies also reveal that health care providers grossly overestimate the comprehension level of their patients.

Caption

The effective delivery of health care services to vulnerable populations must take into account special characteristics:

Lower levels of access to medical care: Research from multiple countries suggests that vulnerable socioeconomic and racial/ethnic groups have lower levels of access to care. These groups tend to have high needs for medical care and their level of use must coincide with their level of need.

High unmet needs: Often, the entry point of these individuals into the health care system is through non-optimal delivery sites for medical care. For example, in the United States, crowded emergency rooms and hospital clinics that are not designed to deal with chronic medical conditions – or to provide preventive health care services – are frequently the primary access point for vulnerable populations.

Long waiting times: For many vulnerable populations, the time spent waiting for medical care is notoriously lengthy. One U.S. study found that walk-in patients without an appointment waited an average of seven to eight hours before receiving medical care at a large hospital's ambulatory-care clinic.

Little preventive care: Disadvantaged groups have lower levels of education and knowledge of healthy behaviors. They are more likely to benefit from improvements in primary and preventive care.

Disproportionate burden of disease: The poor have higher rates of death, disease, and disability, and frequently have multiple chronic medical conditions with multiple high-risk behaviors.

Lack of coordination of medical services: In some societies, such as the United States, a broad range of narrowly focused agencies provide different health and social services to vulnerable populations. An underserved mother with limited mobility may receive each of the following services at a different site: prenatal care, family planning, well-baby clinic, nutritional supplemental services, immunizations, and acute care for a sick child.

Examples Of How Such Needs Can Be Addressed

The Center for Health and Wellness is a state-of-the-art primary health care facility in Wichita, Kansas. It places heavy emphasis on prevention and wellness education, and on decreasing high-risk behaviors. It attempts to deliver a seamless continuum

of health care services and has partnered with a broad range of service providers to offer a coordinated network of community support, Williams said. One of the Center's unique and important features is that questions about insurance coverage or payment for care are not raised until the end of the health care visit, when the individual has already received all the needed medical care.

Another example, the Lafrontera Center in Tucson, Arizona, primarily serves Latinos and, when its doors first opened, reached out to identify and serve Latinos in need of mental health care. Bilingual and bicultural social workers walked through the community introducing themselves and their services.

"In India, one individual came up with a project to improve sanitation. It made a huge change in that one village. Now other villages are asking for his help."

– Anil Dhar

Service providers also established collaborative working relationships with other community organizations, such as public health and juvenile justice agencies, public libraries, and a local Spanish-language radio station. The Center took programs to the people. They developed creative approaches for engaging people within the community setting.

Other evidence indicates that ethnic-specific health programs that develop and use culturally responsive techniques have been effective in increasing use of services among minority groups.

PROGRESA, a Mexican anti-poverty program, combines a traditional cash transfer program with financial incentives for receiving health care services. The program's goal is to improve the health of the next generation by ensuring that poor infants receive the appropriate care. "They believe that health and nutrition interventions early in life could be the key for children of poor families to improve their socioeconomic prospects, as well as their physical and cognitive development," Williams said.

PROGRESA is an acronym for Programma de Educacion, Salude y Alimentacion, or Program for Education, Health, and Nutrition. The program disburses cash transfers to poor families on the condition that they engage in behaviors designed to improve health and nutrition. These include prenatal care; well-baby care and immunization; nutrition monitoring and supplementation; preventive checkups; and participation in educational programs regarding health, hygiene, and nutrition. In addition, cash transfers are given to households with school-aged children if the children are enrolled and attend school. PROGRESA is part of a national program of the government of Mexico.

Taking the Social Context Seriously

More generally, Williams believes that, to the extent that health care services take into account larger environmental conditions, the effectiveness of health delivery will be enhanced.

Sounding a clarion call that would be heard over and over during the Salzburg Seminar, Williams decried the lack of worldwide awareness and action on the HIV/AIDS epidemic. He welcomed what he called "the growing debate on the globalization of health problems, needs, strategies, and necessary resources."

In the United States, a recent Institute of Medicine report emphasized the need for health care delivery systems that are safe, effective, patient-centered, timely, efficient, and equitable (Committee on the Quality of Health Care in America 2001). The Committee stressed that the health care delivery system was in need of fundamental change. Just trying harder within the context of the current system will not bring about the desired outcomes. Making the system better requires changing the system.

Williams concluded with the 10 rules for the redesign of care outlined by the Committee:

1. Care based on continuous healing relationships.
2. Customization of care, based on patients' needs and values.
3. The patient as the source of control.
4. Shared knowledge and free flow of information.
5. Evidence-based decisionmaking.
6. Safety as a systems property – the system should be transparent and patients should be able to understand everything occurring, both in individual care and in the care provided by institutions.
7. Transparency – patients should have access to information about how the system is performing.
8. Anticipation of needs.
9. Continuous decrease in waste.
10. Cooperation among clinicians.

How Gender and Equity Shape and Distort the Crisis in Health Care

Timothy G. Evans
Director of Health Equity
Rockefeller Foundation, New York, United States

What do we mean by "health equity?" Evans defined it "as a world in which any group of individuals, by age, gender, race/ethnicity, class, or residence, can achieve its full health potential." Yet, health inequities are found in many such groups and across the globe. And according to Evans, society at large has generated health inequities of which we currently have little understanding or ability to affect.

"There is an emerging global solidarity for access to HIV/AIDS drugs. It's tied to a moral ethic, a moral responsibility to get life-saving drugs to large populations that would otherwise die."

– Timothy Evans

We can perhaps best describe health care and health-outcome inequities by viewing them across a spectrum of social stratifiers including place of residence, religion, occupation, gender, race/ethnicity, education, socio-economic status, and social networks/capital.

Does inequality matter, as long as improvements are taking place in the world? From an economic standpoint, some believe not. So it is necessary to look at health, both within and aside from economic considerations.

The most significant global inequality relates to gender and sex. Poor women and poor girls are more likely to die between birth and age five, relatively independent of the rate of poverty. Even in countries relatively well off, there is a similar situation.

There are also "missing men," as noted by David Williams, particularly in Russia. By the late 1980s and '90s, the male mortality crisis in Russia was unprecedented in global history. From 1990 to 1994, males lost seven years of life expectancy. "Such a gap has never been recorded anywhere on Earth, ever," Evans observed. "There were a variety of causes, not just alcoholism. We always think and talk about women and children as the vulnerable groups, but in Russia it appears to be adult men."

What is fair when comparing survival between men and women? Equality might appear unfair given women's expected advantage in longevity over men, he said. This expected inequality may actually be "fair" and gives rise to the notion of shortfall equality – the idea that health performance needs to be compared against a norm for each sex, not by gender comparison.

Who is sicker? Paradoxically, females report greater illnesses across all age groups, but live longer.

"Seems strange, doesn't it," Evans said. "Are we seeing the pains of reproduction, of child rearing? With all controls, women report more ill health. Women actually live longer, but in poorer health. Is this because the health system is not responsive to their needs? Some studies indicate that is frequently true."

Risks of Ill-Health

More than 60 percent of men in Southeast Asia smoke cigarettes. And globally, more young women now smoke in Latin America, Asia, even Africa. Young women are more biologically susceptive to HIV infection and have less opportunity to control and protect themselves.

There are gender inequalities in health research as well. Drug trials frequently exclude women because of trying to "protect" such trials from female-related factors. Yet these drugs are then often given to women, Evans said.

Health systems don't plan for gender-specific needs. There are a lot of stereotypes and biases as to patient perceptions. And there is frequently lack of gender balance among health care providers with men as doctors and women as nurses.

"The revealed behavior of health systems is that economic status determines access to care. There are also risks associated with impoverishments," Evans said. "The richest people, in general, also consume a disproportionate amount of hospital and public health care. Yet the health care needs of the poor are more pronounced."

So how do you organize health systems to reverse this problem?

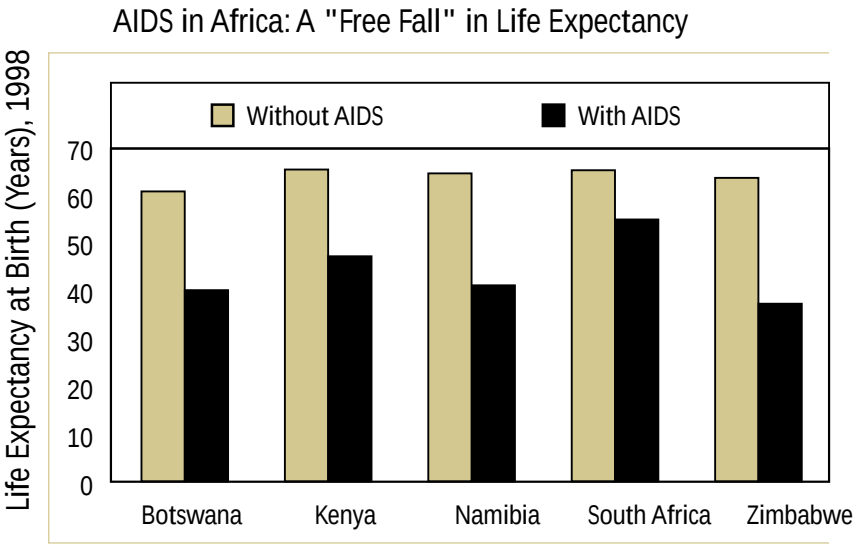
"We need to set specific equity targets, that are both symbolic and practical," Evans said. "There should be financial reforms to remove disincentives; to think creatively about health risks

that correlate with poverty over time. It is incredibly important to find a way to intervene with the increased use of tobacco by the poor."

Then there are forces in health systems that promote separation and integration. Women and men's health have become specialties – for example, hospitals, medical practices, and textbooks that address health promotion and medical treatment primarily from a woman's biological and social perspective. There are associated benefits and additional costs to society. "Are we going to see a divergence where specialists only treat women? Or men? Is this going to contribute to better health care for individuals, groups, and society?" he asked. "Can we afford to continue down this track?"

The trend toward integration came out of the Cairo plan of action at the 1994 International Conference for Population and Development. There, a $17 billion road map for gender equity in population and development was laid out. But that map has been difficult to get countries to follow; and the actualization of that agenda has been slow.

Evans noted that great headway has been made in some areas relative to the practice of gender equity. In Kerala, India – women's education; in Sri Lanka – universality in social services; and in Bangladesh – microcredit for women in poor households. Such interventions empower women, and thereby have a positive impact on child mortality.



Source: U.S. Census Bureau, World Population Profile, 1998

The AIDS "Free Fall" in African Life Expectancy

The world has never seen such a sustained health catastrophe as AIDS, and it's not over yet. And it's not going to get better tomorrow. It is the most important health problem we have ever faced, Evans asserted.

Six of every 10 new HIV cases afflict women. There is overwhelming need for a female controlled technology for HIV prevention. There should be massive investment in clinical trials in these countries, and especially the African continent.

"Differences in mortality rates represent the greatest human inequality in the world."

– Timothy Evans

Evans outlined some of the strategies now being supported by the Rockefeller Foundation: increased research on heterosexual transmission, which has increasingly become the mode of transmission for HIV/AIDS. There are also opportunities for development of new technologies to address this problem through microbicides.

And what about the millions of people already infected?

We must deal with the one-third of the adult population in many countries who are infected with HIV/AIDS. Evans is working with the Rockefeller Foundation on an effort to accelerate care for those already infected.

"There are millions of reasons not to do it; however, to do nothing is completely unacceptable," he said.

Rockefeller is looking for points of entry within social constituencies, specifically the mother/child axis and maternal-child services. One approach seeks to prevent transmission of AIDS from mother to child during pregnancy through use of a relatively inexpensive drug that is now available.

Persistent Problems, New Approaches in China

Yan Guo
Professor and Vice Dean, School of Public Health
Peking University, People's Republic of China

China's dramatic economic growth over the past two decades has brought with it disparities in access and availability of health care between rich and poor, rural and urban citizens, insured and uninsured. The nation is attempting to implement new health policies and practices to close the health care gap among its people, Guo said.

"There is still a tremendous sense of family commitment and responsibility across generations in China," Guo said. "While there are fewer four- or five-generation families living in one household, Chinese feel an obligation to support their extended family – no matter what that takes, including impoverishment of the whole family to provide health care for one family member."

– Yan Guo

With a population of 1.26 billion, China is the world's largest nation. It has also experienced rapid economic development, with an annual Gross National Product rate of 8.3 percent from 1991 to 2000.

From the mid-1950s to the 1970s, the government under Chairman Mao stressed what was termed the "Patriotic Health Campaign." It was a nationwide effort aimed at disease prevention, with priority given to rural health services, integration of traditional Chinese medicine with Western medicine, and the strengthening of health manpower training.

At their peak in 1970, China's agricultural communes provided basic medical coverage to about 90 percent of the rural population. "Barefoot doctors" were chosen at the village level, given short-term medical training, and delivered free health care services, with associated costs covered by the village or higher governmental unit. A governmental insurance system also provided free medical services for workers in urban areas, Guo said.

Today, many rural areas cannot afford to provide health services, and the poor cannot afford to pay for the services. Since the early 1980s, only 7 to 10 percent of China's rural population, and only about half of its urban population, have

been covered by health insurance. Forty percent of households in rural China are below the poverty level; a principal reason was their need to spend family resources to cope with significant illness.

"There is still a tremendous sense of family commitment and responsibility across generations in China," Guo said. "While there are fewer four- or five-generation families living in one household, Chinese feel an obligation to support their extended family – no matter what that takes, including impoverishment of the whole family to provide health care for one family member."

Expenditures and costs for health services have skyrocketed in China. Outpatient and inpatient costs from 1990 to 1997 increased by nearly 500 percent. A 1992-93 survey found that, of those referred to a hospital for care, 41 percent did not seek hospitalization because of excessive cost and inability to pay.

In China, chronic diseases such as strokes and cancer now account for two-thirds of all mortality, Guo said. Both are strongly associated with smoking tobacco. China has more than 320 million smokers, who consume 30 percent of the world's cigarette production. If current trends prevail, by the year 2025, there will be 2 million tobacco-related deaths a year and 900,000 deaths per year from lung cancer. From 1990 to 1995, tobacco sales in China increased by 28 percent.

Among the poorest 25 percent of China's rural population, the infant mortality rate is 3.5 times greater than in cities. Women and children, particularly in rural areas, are most vulnerable to the decline in China's health care system and social safety nets, Guo said. There also is substantial regional variation of health status, with people living along the ocean coastline enjoying higher incomes and better health than those in China's central and eastern provinces.

Today, hepatitis B is found in 10 percent of China's population, and in 1997 there were 418,903 identified cases of tuberculosis (TB), with 80 percent of cases found among farmers. Among pulmonary TB patients in China, 75 percent are between the ages of 15-54, "the most productive years of their lives," Guo observed.

Quality of health care also is being affected by inappropriate use of medications, especially antibiotics and injections, with risks of antibiotic resistance and blood-borne disease. Other

related problems stem from inadequate sterilization, lack of quality control over pharmaceuticals, shortages of medical equipment and private medical practitioners, and inadequate supplies and training for health care workers.

Guo said that China is also facing the emerging impact of the worldwide HIV/AIDS epidemic. There are an estimated 400,000 infected persons in China, and some 40,000 additional patients are diagnosed with AIDS each year.

How is China attempting to address its critical health care disparities? Guo said five principles are now guiding health care developments in China. They are:

- Emphasis on prevention;
- Priority attention to rural health service;
- Integration of traditional Chinese medicine with Western medicine;
- Strengthening of health manpower training; and
- Flexibility in further development of medical and health services.

Because of the glaring gap between urban and rural health care, the Chinese government is sending doctors to the countryside, and shifting funds from urban to rural areas. They also have set up a health care poverty-relief fund in poor areas of the country.

There are, Guo said, dichotomies between China's relatively new hybrid society that is attempting to graft a capitalistic-driven economy onto a socialist form of government. The challenge is to bring improvements to Chinese citizens, especially the peasants who represent 80 percent of the country's population.

New attention is being placed on better education and training of rural health personal, on providing reasonable compensation for rural health care personnel, and on improving standards and management of rural hospitals and clinics.

Getting the Facts To Influence Change in Your Country, Around the World

Orvill B. R. Adams
Director, Department of Health Service Provision
World Health Organization, Geneva, Switzerland

The World Health Report 2000 put forward a concept of health outcomes, or goals, to measure the level of health, its distribution, and the responsiveness of the health care system.

"Health care systems treat different people differently. We need to look at the financing of health care systems, how they are organized, and do they bankrupt or put people in poverty?"

– Orvill B. R. Adams

"Health care systems treat different people differently," said Orvill B. R. Adams, director of the Department of Health Service Provision for the World Health Organization (WHO). "We need to look at the financing of health care systems, how they are organized, and do they bankrupt or put people in poverty?"

There is much debate about health-system performance, which has forced international and national policymakers to take a greater interest in health systems improvement across the globe.

"We see now that the issue is 'higher on the table' of national priorities for policymakers, consumers, health care professionals," Adams said.

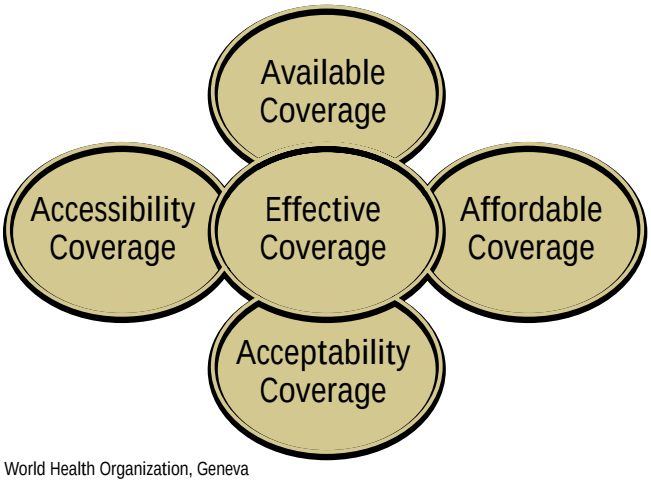
Adams called for more focus on health-system goals. Particularly important are issues of financing, resource generation, provision of services and stewardship, and public responsiveness. "We need to look specifically at the proportion of the population who are in need of a health intervention who have received that intervention," Adams said. "At the same time, health care systems must attempt to deliver and respond to a wide array of services and needs. A set of interventions must be examined."

The World Health Organization is pilot testing a preliminary coverage "module" in 12 countries worldwide. Adams said WHO is interested in measuring health coverage interventions based on the following six criteria:

- Ability to produce a significant health gain in relatively short time;

- Size of a health problem at global and country levels – the burden of the disease;
- Evidence of an intervention's effectiveness and credibility;
- How well it corresponds with national health policies and priorities, and objective needs;
- Balance between different modalities of health care and between different illnesses (those that are communicable or life-cycle related, for example); and
- Low cost of obtaining information at country levels.

Domains of Coverage



World Health Organization, Geneva

WHO has settled on such coverage indicators as maternal and child health; malaria and tuberculosis; HIV/AIDS; chronic non-communicable diseases like epilepsy, asthma, diabetes and arthritis; cancer, vision and hearing, road traffic injuries which have been treated with medical care; and water and sanitation considerations.

"WHO wants to reach top policymakers at the international and national levels, not just at the minister of health level," Adams said. "We want to provide good, comparative health data for the heads of state. It's the responsibility of government to ensure quality of health care. And whether such health care is provided has tremendous economic growth implications."

That is why, Adams said, so much emphasis is being placed on WHO's health rankings by country: "We want to reach those countries that have the potential to really improve over time."

Models of Hope in the Face of Adversity

These stark contrasts and deficiencies in health care worldwide should not be viewed as overwhelming obstacles, but used to advocate for greater health care resources and equity, according to Seminar Fellows.

There are many public policy reforms, new collaborations in health training, and efforts at community-based service delivery. Often, the most promising initiatives are taking place in underdeveloped countries. These projects should be spotlighted so that other communities and other countries can adapt them to their own situation and needs.

Several of these "models of hope" were profiled in the following Seminar presentations.

"We need to understand that just making antibiotics available is not enough, not the answer. Comprehensive approaches that include socio-economic challenges are required."

– Erve Bottex

Haiti: A Crisis Brings a Model for Community Participation in Public Health Care

Erve Bottex
HIV/AIDS Family Services Coordinator
Volunteers of America, New York, United States

Can primary care respond to today's health care challenges, particularly in developing countries? If so, what is the role of the community?

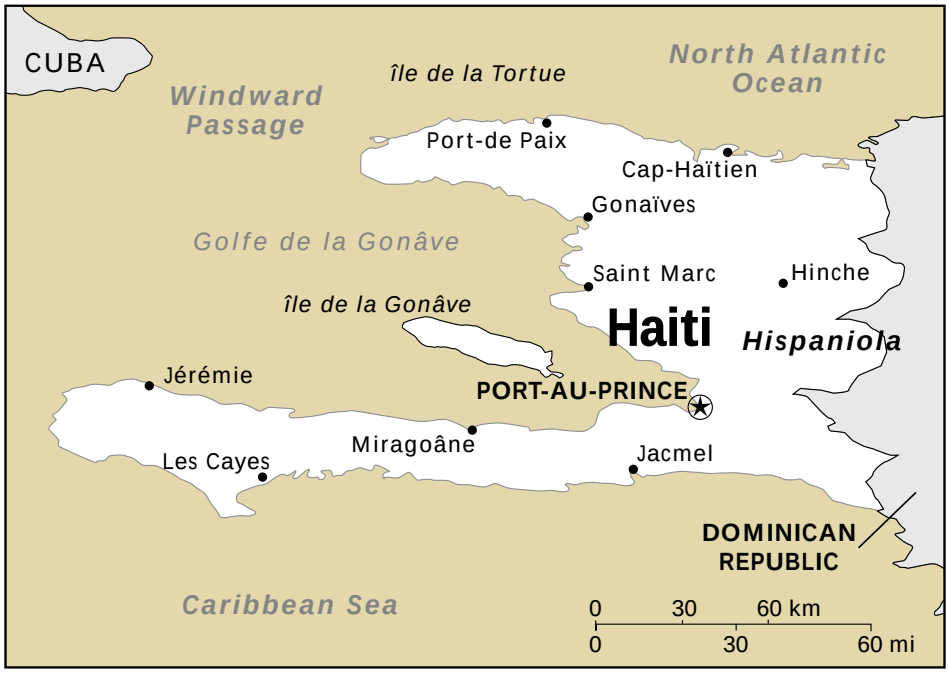
Speaking from his experiences as a physician and program director in Haiti, the poorest country in the Western Hemisphere, Bottex said that for most developing countries, selective health services have replaced comprehensive approaches to primary care.

"This reality has been driven by the international funders, the World Bank, the International Monetary Fund, and others," he said. "We need to understand that just making antibiotics available is not enough, not the answer. Comprehensive approaches that include socio-economic challenges are required."

Haiti's current population of more than eight million is expected to double by the year 2024, which will represent an incredible burden for the impoverished country. Eighty percent of Haitians live in poverty.

In Haiti, the infant mortality rate is 345 per 100,000. Two-thirds of all children under five years of age are malnourished and 160 out of 1,000 youth will die before they reach five years of age.

He described the Community Oriented Primary Health Care (COPHC) initiative based at the Albert Schweitzer Hospital in Haiti that serves an area population of about 258,000 residents.



COPHC includes a 108-bed hospital, 12 community health centers, and 500 community locations that serve as entry points of preventive health services.

Bottex said that from its beginning in 1993, this comprehensive primary-care project developed a health care information system where each village tracked changes in health care. The project has stressed four principles of community-based care:

1. The family is the key primary health care provider; and the health care worker is the family's enabler or trainer.
2. There must be equitable distribution of preventive health services to everyone in the community.
3. Community involvement with services and feedback are important, and can be achieved by locally trained health care visitors.

4. There must be ongoing health and child surveillance activities and preventive services (distribution of contraceptives, deworming, active efforts at finding tuberculosis cases).

The project's overall goal has been to show how such a community-oriented effort could have measurable impact on a poor Haitian community. And equally important, how a similar model could be used to combat infectious diseases and malnutrition in other parts of rural Haiti.

The malnourishment of their children was the chief, expressed concern of area residents. Community leaders were then mobilized in each village to identify malnourished children. A trained network of 1,800 volunteer mothers helped provide improved primary health care services, with a goal of rehabilitated malnourished children. Each volunteer worked with 15 families, and helped demonstrate to mothers how they could make a visible, demonstrated improvement in their children's health in just two weeks through basic changes in nutrition and hygiene.

Up to 2,000 mothers also participated in a "microentreprise" income-generating program that taught them how to prepare lunch for school children, set up day-care services, manage a loan, and start a business.

Tuberculosis represents a global challenge, and Bottex said this reality is reflected in the Haitian community. In response, COPHC trained former TB patients to make regular, twice-weekly visits for six months to help ensure that tuberculosis patients had food and medication. With such support, and at relatively low cost, 80 percent of those infected completed their treatment.

In the face of a six percent HIV/AIDS infection rate, few drugs are available in Haiti for treatment. Unlike TB infection, there is great denial among those infected with HIV/AIDS. Hospice care was established for HIV/AIDS patients, and more than 1,000 church leaders, voodoo priests, and teachers formed health groups that promote AIDS prevention and patient care.

"This seminar has been the most exciting experience in my public health administration career. I can put in practice a lot of ideas and inspire my colleagues to dream for a better health system, in Buenas Aires."

– Fernando Mazza

Colombia: Unlikely Partners Unite to Challenge Negative Aspects of Public Health Reform

Ligia de Salazar
Director of the Research Evaluation Center in Public Health, CEDETES
Universidad del Valle, Colombia, South America

In Colombia, Ligia de Salazar says that health care is both a public service and a human right guaranteed in the nation's new constitution. Recent governmental health reforms in Colombia and other developing countries have increased basic health services; the number of people insured; and in some cases, the amount of money available to subsidize health care. There has been a reduction in per capita health care expenses for the poor. However, these reforms have also had negative impact on access and quality of care, Salazar said.

"Health professionals have not been adequately prepared to participate in the reforms. There's been limited community participation; a traditional, paternalistic culture that too frequently serves specific political parties."

– Ligia de Salazar

The challenge has been to document health care problems, as both a way to improve health-service equity and as a strategy for strengthening community participation in decisions related to their own health and well-being, she said.

The result has been privatization of many health institutions and services, as well as a decentralization of services that has weakened local health services while, ironically, providing new opportunities for local participation.

"Health professionals have not been adequately prepared to participate in the reforms. There's been limited community participation; a traditional, paternalistic culture that too frequently serves specific political parties."

"Health care reform in Colombia takes place in a complex environment that includes citizens, policymakers, insurance institutions, health care providers, the pharmaceutical industry, and education/research institutions," Salazar said.

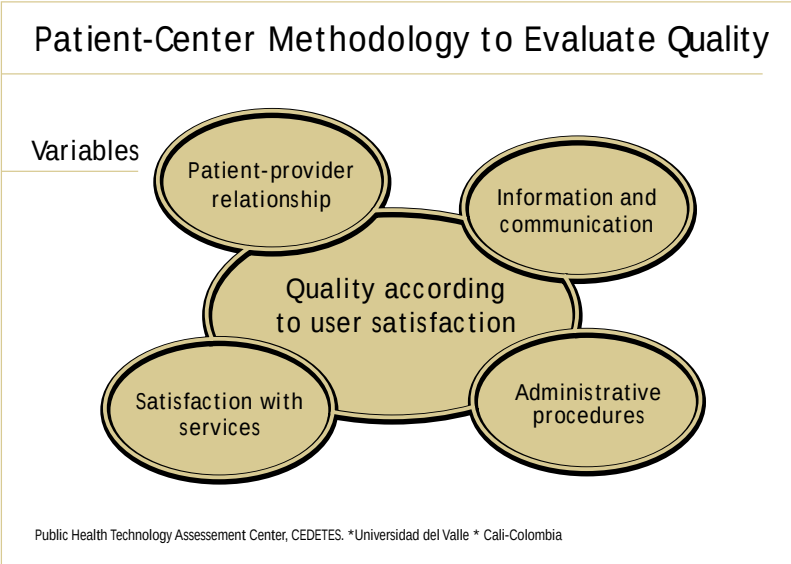
"They all bring different viewpoints, agendas, needs, and expectations. So often the real question is how to develop a common agenda that includes all of these players, and that is

still oriented to equity in both access to and quality of health services. We need evidence about interventions and the health of people."

The community selected has about 100,000 low-income residents, a relatively high incidence of violence, underemployment, and water contamination, as well as lack of adequate sanitation, and low-level access to health services.

The emphasis is to move public participation to the political arena. Accordingly, community advocacy has been built through public dialogues and debates involving community organizations, public officials, university faculty and students, and news media. Training was provided so that people were comfortable and open about expressing their views and opinions. "We've learned not to underestimate the ability of people to express their opinions," she said.

Health Services Quality Assurance Community System



For the first time, efforts were made to solicit citizen/patient evaluation of health services and needs, and to use these findings as part of health care reform efforts in Colombia. What are the health determinants in the community, specific risks, and interventions? A community information system was developed across socio-economic strata.

As a result of the project, the Universidad del Valle's School of Public Health is now undertaking a curricula reform, with the objective of producing public health professionals more suited to the needs of the population, and who can be active partners in social change, Salazar said.

She encouraged other developing countries to adopt new strategies of citizen participation in health policy and service reform. Success hinges on documenting changes in health status at the community level.

Peru: Moving From Health Costs to Health Investments in Community Care

Ricardo H. Dios Alemán
Total Quality Management Consultant
Pathfinder International – World Health Organization Project 2000
Peruvian Ministry of Health, Lima, Peru, South America

What if we can find other routes to health and healing? Reduce costs but offer services to people who need them most? Create health systems that work as hard to prevent disease as to treat it? Approaches that include a social and community perspective, and connect patients and health caregivers in a way no computer ever can?

"Too often, universities are not being asked, challenged about the social relevance of their work. And, in my country, university accreditation is now changing to place more emphasis on this social responsibility and involvement."

– Ricardo H. Dios Alemán

Such a system does exist, according to Ricardo H. Dios Alemán, in the poor Moche community of Trujillo, Peru. It includes both clinic and classroom strategies; students, teachers, and lay people growing together – a partnership between community leaders and volunteers, the government's area health services, and the University of Trujillo.

Fifty percent of Moche residents live in poverty, Dios Alemán said. Seventy-five percent have no access to running water or electricity. "It is an environment where sickness and disease flourishes, particularly infectious diseases. Respiratory and gastrointestinal problems are most common in children," he said.

At the beginning of the project, health services were organized according to the illness, not to the person. Many health demands and needs of the individual were never identified. Health workers functioned separately and used resources ineffectively. Health workers were responsible for activities, not for results in citizens' health improvement. Social participation was limited.

"The University was using the community as an extension of the classroom – there was no real commitment by the University to improving the community," Dios Alemán said. "Too often, universities are not being asked, challenged about the social relevance of their work. And, in my country, university

accreditation is now changing to place more emphasis on this social responsibility and involvement."

Dios Alemán said intensive negotiations were held with regional government authorities to obtain clearance to make modifications in health-service delivery. They also requested the government to recognize and accept full participation of community and university leaders in the project. This included the sharing of opinions, ideas, and improvements in health promotion and clinic care.

Multi-disciplinary teams, along with volunteers, blanketed the community with health outreach programs and services. The teams included a nurse, psychologist, midwife, and nutritionist. University students from these areas are also included in provision of services. "Over time, these students and citizens started to question how health services have been provided, actually challenging the health system to change in positive ways," Dios Alemán said.

Health promotion teams now go door-to-door in Moche to collect health histories and provide information. This informal but structured monitoring identifies the presence of infants; pregnancy; women in reproductive age with more than three children; malnutrition in children under three years of age; infectious disease; access to drinking water; sewage and electricity; presence of chronic disease in the family; illiteracy of the person in charge of child care; where there are more than five dependents; and other family social problems like alcoholism, drug addiction, or family abuse.

The health promotion team members make referrals for treatment. They use handwritten records to chart health status and risk of residents. And then, working in geographic sectors, based on the health risks identified, specific steps are used with each family. The approach relies as much on trust as technology, Dios said. One family at a time, health promoters break down the barriers that prevent local people from seeking care. The concept of family assessment did not exist prior to the project.

People in the community are more comfortable talking to a person from health services. It has not been easy to win over health professionals like physicians, but the project's success has made progress with its skeptics.

Health teams were organized to respond to integrated needs of specific age-related groups, for example, infants, teens, women, and senior citizens. After more than five years, the

Moche district's health services have been able to maintain the new approaches to health intervention, and the improvements in health have also been consistent.

Dios Alemán noted that cities and communities in the United States, including New York and Miami, have adopted aspects of the Moche project model.

"If we listen to each other, how would our health systems be different? Could we harness the compassion of volunteers? Could we stress disease prevention as well as health care?" he asked. "We've been trying to answer those questions in a positive way, one that shows results in the lives of vulnerable, poor people. You can't just replicate the commitment, the passion, the personal contact that makes this project successful. But you can find your own and build on it where each of you live and work."

"Changes cannot happen within individual hospitals and health care systems. Collaborations and partnerships are critical."

– Vernice Davis Anthony

Health Care in the United States: Dangerous Myths, Exciting Opportunities in Detroit and Elsewhere

Vernice Davis Anthony
Senior Vice President, Corporate Affairs and Community Health
St. John Health System, Detroit, Michigan, United States

Is quality health care a right or a privilege? Is it for those who can afford it or is it for all? Vernice Davis Anthony believes the answer to these questions lies in embracing the power of collaboration between stakeholders, including hospitals, grassroots community organizations, legislative bodies, public or city health departments, and community residents.

That was the consistent message from presenters from all across the world during the Salzburg Seminar, she said. And nowhere is this more important than in the United States, where there is the prevailing myth that America is always a "model of prosperity and freedom," including access and availability of health services for all its citizens.

A report by the Institute of Medicine notes that, for the past 25 years in the United States, the number of uninsured citizens has grown by about one million each year. And this

rate of uninsurance persisted, even during times when the American economy was strong. Health care costs have outpaced the rise in real income, with this problem fueled by the needs of an aging population, advances in medical and pharmaceutical technology and the cost passed on to people and systems, and the growing exercise of "consumer choice" in health care service options.

Anthony cited four common myths about medical care in the United States and those citizens who cannot afford health insurance for themselves and their families.

The reality, she said, is quite different from these myths. For example, uninsured Americans are much more likely to go without needed health care. Nearly 42 million Americans lack health insurance coverage, and this number includes 10 million children – 15 percent of the country's total population. More than 80 percent of uninsured children and adults live in working families. Immigrants comprise a small proportion – less than one in five – of uninsured U.S. residents, Anthony said.

America's Medically Uninsured - Myths

1. People without health insurance get the medical care they need.
2. The number of uninsured Americans is not particularly large and has not been increasing in recent years.
3. Most people who lack health insurance are in families where no one works.
4. Growth in the numbers of recent immigrants has been a major source of the increase in the number of uninsured persons.

Socioeconomic factors are also critical, she noted. Two-thirds of all uninsured people are from lower-income families, and more than one-quarter have not graduated from high school. African Americans are twice as likely as non-Hispanic whites to be uninsured.

More federal control over Medicaid and less money for Medicare has meant a "retreat by the poor from the primary-care doctor's office toward the hospitals' emergency room" as the last resort for health care services. The poor and uninsured are "financially barred from the primary-care doctor's office. They go to the hospital emergency room. There is no continuity in their care."

For public hospitals in America, the result has been a near disaster, Anthony said. "Lean, well-meaning, accountable public hospitals have been forced to close because of these governmental funding changes and the infusion of hospital

patients without revenue. Some health professionals say: 'No margin, no mission,' if you don't have the dollars you don't provide care. I couldn't disagree more. The mission is serving people."

Anthony is not wearing rose-colored glasses, however, about the financial problems. Hospitals have been overwhelmed by the changes in Medicare and Medicaid reimbursement, and then by managed care, which has effectively eliminated preventive care and much primary care for poor people. The health care institutions relying on these sources, often referred to as America's "safety net" of health services, have been hard hit by these changes. In more and more cities, there are no public hospitals or they are closing, as in Washington, D.C.

Where do people go for health care? Often, they simply don't get any, Anthony said. Poor people fear that hospitals won't accept them. For millions of poor Americans, "I can't afford to get sick, because I can't afford to go to the hospital," is a common lament, Anthony said.

Another factor that signals the need for new, collaborative approaches to health care delivery is the prevalence of chronic illnesses such as diabetes, heart disease, prostate cancer, and infant mortality.

Ten Major Public Health Issues in the United States

1. Physical activity
2. Overweight and obesity
3. Tobacco use
4. Substance abuse
5. Responsible sexual behavior
6. Mental health
7. Injury and violence
8. Environmental quality
9. Immunization
10. Access to health care

Residents of the city of Detroit are 83 percent non-Caucasian. The majority include African Americans, Arab Americans, as well as many Hispanic immigrants. Detroit has high rates of unemployment and poverty, and single parents head 60 percent of Detroit families.

The Surgeon General of the United States recently issued a report, Healthy People 2010, which includes a set of national health objectives. They are intended to help guide communities across the United States to develop programs that: 1) help individuals of all ages increase life expectancy and improve the quality of their life; and 2) eliminate health disparities among different segments of the U.S. population.

As detailed in the Surgeon General's report, it is at the community level where new partnerships are needed to expand access to quality health care and prevention services. Anthony described a project in her home city of Detroit, Michigan, that is striving to break down health care barriers.

The project, known as the "Voices of Detroit Initiative," has included four key partners: The Detroit Medical Center, Henry Ford Health System, St. John Health System, and Detroit's public health agency under the leadership of the city's top elected official, or mayor. All of the partners are members of a much broader Detroit Health Collaborative.

"Changes cannot happen within individual hospitals and health care systems. Collaborations and partnerships are critical," Anthony said. "You have to have a community focus, which is how the Detroit Health Collaborative came to be in 1996. How could we capture tremendous opportunities that existed for collaboration in Detroit?"

The mayor of Detroit had been trying to bring the major hospitals together for a long time. The challenge for them was how to simultaneously compete and cooperate. It took the mayor's leadership to bring the "big three hospital systems" together in Detroit – those that provided $600 million in uncompensated health care in 2001.

In metropolitan Detroit, seven hospitals located in suburban communities generate more revenue, and through the Collaborative, financially help support the three hospitals within the city that serve the largest numbers of poor or uninsured citizens, Anthony said. Each hospital has built up its own strengths through the Collaborative. "We realized that we had not just problems, but strengths, and political clout," she said.

The hospitals represent a work force of 40,000 employees, 3,000 hospital beds, and more than 3,000 physicians.

"So what were our objectives? Creating community change from 'the bottom up.' Moving people out of the hospital emergency room to where they could be served by primary-care physicians in a more private office or clinic environment."

Anthony said they began to work with the Chamber of Commerce so "health care would be seen more as a positive influence on the community, in terms of number of local employees – 40,000 taxpaying citizens from hospitals! And we wanted to try collaborative marketing, because indeed Detroit should be a 'destination point' for quality, sophisticated health care. And we wanted there to be a more equitable economic burden among the hospitals."

"It's frustrating because there are very many simple, inexpensive technologies that we could use. But there is money to be made in tests, in expensive technologies for physicians and hospitals. So it is difficult to overcome this barrier and their resistance."

– Arunas Lukosevicius

With W.K. Kellogg Foundation support, the Voices of Detroit Initiative became more credible and financially stable, and brought together additional community leadership.

"The project is really a set of new relationships, with a commitment to working together, to sharing resources, data, research, best practices, and creating a community voice for health care change in Detroit," Anthony said. "We also want to track hospitals' emergency-care users, so we can begin moving people into a better primary-care service environment. And we want to nail down what the actual costs are for providing primary care for the poor. So far in that process, we've found that Detroit receives a lot less from the federal government than similar cities across the United States."

At the table were not only individuals, but also representatives from such major organizations such as churches, health councils, the Health Care for the Homeless group, Michigan Legislative Black Caucus (the association of black state politicians), Chinese Americans, the Hispanic Development Corporation, African-American groups, United Way, and the Detroit Chamber of Commerce. "We wanted as many people inside the coalition's tent as possible," Anthony said.

Almost $1 million in new federal money was garnered for health care for the poor, through the new collaborative. It also has received matching funds from the St. John Health System.

What has been accomplished? This eight-year relationship has resulted in more than 9,000 poor residents enrolled in Medicaid or Voices of Detroit care programs. Pharmacy and dental case

management has been put in place, a tracking system for the uninsured initiated, and a new community advocacy group formed around public health care issues.

Specialty care is still a problem. "The Medical Society came into the project late, and we learned from that the need to integrate physician and provider involvement very early on in such an effort," Anthony said. "Another challenge was all the decisions around data, the cost of developing it, confidentiality, and legal issues. There were concerns about funding and sustainability, especially in the face of the current deficit that's facing the Detroit city government.

"You need funding to just help people stay in the process. We want to integrate the Detroit Voices model into the city government and we've met with Detroit's new mayor with that goal in mind. We want new primary-care clinics. We want to expand primary-care enrollment for poor people, and that requires building the necessary delivery network. And then issues around advocacy are always there. This happens to be an election year in Michigan. There will be a new state governor. As the federal government moves responsibilities to the state, this relationship becomes even more critical."

Anthony said there also must be a common vision among the major partners, along with visible involvement by key policymakers. "The community must see itself involved, and you have to avoid duplicating programs or services that are already being provided by your partners. Use what's put on the table – whatever the resources might be, because that results in a lasting stakeholder role being established."

Ethiopia Overcomes Politics, Turf Issues, to Collaborate in Public Health Training and Service

Mesfin Addisse
Head, Department of Community Health
Gondar College of Medical Sciences, Ethiopia, Africa

With very limited educational resources and tremendous public-health needs, can a developing country train the professionals it needs to address complex community health problems? Ethiopia, a country in East Africa bordered by Sudan, Kenya, and Somalia, has managed to do just that in the face of recent political and social upheaval, according to Mesfin Addisse, head of the Department of Community Health at Gondar College of Medical Sciences in Ethiopia.

"We were also concerned that students – just like their teachers – adopt an interdisciplinary, team approach to their own learning and practical apprenticeship. We wanted them to have direct clinical contact at the village level."

– Mesfin Addisse

Ethiopia has a population of 65 million, 47 percent of whom are under age 14. The population growth rate is three percent and Ethiopia's child mortality rate is near that of Haiti, at 100 per 1,000 children. Child mortality before age five is 600 per 1,000 – an incredibly high rate. The average Ethiopian woman has 6.5 children. The rate of HIV/AIDS infection is 112 per 1,000 residents.

Health care has been decentralized, and in 1992, a government change forced the military from political control and power. Former U.S. President Jimmy Carter visited and talked with the Ethiopian Prime Minister about ways to improve public health, Addisse said. As a result of this dialogue, the Carter Center in Atlanta, Georgia, provided resources and consultants to help look at public-health needs and opportunities for change in Ethiopia. The government decided that infectious diseases, which are the most common cause of mortality, would be a focus of its preventive health efforts.

The government wanted to establish 600 new health centers throughout the country, with each center serving at least 25,000 people. Ethiopia had a very successful, university-based public-health training program in the 1960s and 1970s. But the military government forced faculty members out of the universities and closed the program. As a result, the country

has lacked individuals who could teach what the health providers need to know to operate the new centers.

The five major teaching universities came together to establish a collaborative educational program to train the teachers. "Few teaching materials existed, so we developed our own," Addisse said. "Training modules were designed by groups of up to 25 individuals from the institutions, representing an interdisciplinary cross section of public health, family planning, nursing, and medical technology. So our focus was on prevention at the community level – and to train individuals who were really committed to community-based health care. The faculty developed team-teaching approaches, and rotated among the universities so they could benefit from other colleagues and different teaching approaches.

"We were also concerned that students – just like their teachers – adopt an interdisciplinary, team approach to their own learning and practical apprenticeship. We wanted them to have direct clinical contact at the village level," Addisse said.

The new program requires students to spend from one to two months in a village, as part of a multidisciplinary student team. They are also required to complete a health status audit, and develop a specific plan for health promotion and care, in collaboration with village leaders.

Addisse said the program has shown how a poor nation, with daunting problems in public health and scant instructional personnel or resources, can design an effort that makes the best use of what is available; that trains both teachers, and their students, in community-based health prevention and care.

"The Soviet Union made their satellite countries economically dependent by providing energy, health care subsidies, and other resources. Now that these countries are free, they can't afford anything. We need to learn more from those countries in Europe with shared or similar Baltic cultures. Change, improvement is possible."

– Arunas Lukosevicius

"The 'ideal' health care system should promote and protect people's wellness without discrimination, and be based on community participation."

What Can We Do? Elements in Shaping a New Model for Health Care

Breaking up into four smaller groups, the Salzburg Fellows met daily to focus on the facts and implications of health inequity among vulnerable populations worldwide. Each group took elements from the Seminar's general presentations, blended them with their own individual experiences as health professionals and within their smaller group, and then identified elements of an "ideal health care system" that would be broad enough in scope to bridge cultural, economic, and political differences.

As one Fellow commented: "We learned through our small group work not to underestimate the power of a few people, of like mind, to bring about change in a single country. More than anything else, that's what each of us will take with us when we go home. The Seminar is not the end. It is the beginning of a change process, and a new awareness for many of us."

Carlotta Arthur
USA

Group A: Develop a Single Movement, Built on Partnerships and Alliances

John Baldwin
USA

Group A represented 13 different countries, people from education, law, health care, economics, and many diverse professional settings. They expressed a bit of surprise at the universality of health problems worldwide.

The group was challenged to link information, technology, finances, and human resources when developing an "ideal" health care system. Peoples, families, and communities are suffering from exclusion from health services, and that was the starting point for Group A. "How can we change their situation?"

Bruno Benavides
Peru

The first step is for advocates to act in a single movement, through partnerships, alliances, and collaborations, which the group gathered together under the heading of "The Reformer." The Reformer must have a vision of what the health care system should look like. It must be responsive to a nation's or a community's cultural, economic, and political realities, but also represent universal characteristics and a set of core values.

"The 'ideal' health care system should promote and protect people's wellness without discrimination, and be based on community participation."

Such a system will emphasize human rights and democracy and have a strong people orientation. Financial accountability has to be a cornerstone.

"Bureaucracy, finance, lack of access, maldistribution, inefficiency, and discrimination must all be overcome to realize a dream, a vision, and a reality of new health care delivery," the group commented in a closing summary.

The group proposed a specific set of "tools" that can serve as checkpoints in the process of health care reform. These include:

Damira Bibosunova
Kyrgyzstan

Esmeralda Burbano
Colombia

Diane Calleson
USA

Jerry Rebaza Campos
Peru

Tools for an Ideal System

Information

- Must be credible and universally available
- Selected most important indicators
- Underlying health care system to support good data generation
- Minimize paper work
- Training of providers to collect and analyze data
- Data lobe collected at appropriate level by users of data
- Evidence-based health activities
- Uniformity of data across departments regions, borders
- Security and confidentially of data

Technology

- Equitable distribution of technology
- Cost-effectiveness
- Affordable and available for popular use
- Public health agenda should drive technology market
- Update technology with current practice
- Telemedicine

Finances

- Appropriate prioritization and distribution across societal sectors
- Appropriate distribution within heath system
- Align budget with community -driven heath needs
- Align incentives with objectives
- Accountability
- Reconcile public and private sector

Universal Coverage

Human Resources

- Should be seen as social investment
- Global agreement regarding distribution of human resources
- Legislate to ensure equitable distribution of human resources
- Coordination between different ministries
- Inter-disciplinary training for providers AND managers

Paulo Capucci
Brazil

Yusuf Celik
Turkey

Dionne Colbert
USA

Mae Tomiko Conner
USA

The group emphasized its belief that incremental or sequential changes do not work when a paradigm shift is needed in solving a persistent, multi-dimensional problem like health care access, equity, and quality for all. It set forth its own list of 30 "building blocks" necessary for an ideal system.

Group A's 30 'Bricks' for Building an Ideal Health Care System

1. Sustainable
2. Balance between protection and attention
3. Caring
4. Orientation
   - Patient-centered
   - Family-centered
   - Community-centered
   - Population-centered
5. Universal access - not dependent on patients' economic status
6. Socially responsible
7. Optimization of health/wellness
8. Quality-driven standards of performance
9. Care acceptable to the community (the people)
10. Community ownership
11. Addressing root causes of problems
12. Evidence-based
13. Outcomes-based
14. Coordination between planning and budgeting among programs
15. Integrated intra- and inter- system
16. Optimize balance between decentralized and centralized processes of care
17. Well-managed resources
18. Collaboration and integration among societal sectors (i.e., religion, education, economy, etc.)
19. System designed by all users
20. Alignment of incentives for all users and providers
21. Must be productive and efficient
22. Appropriately funded
23. Equitable distribution of resources
24. Emphasis on education, specifically health education, promotion, and early intervention
25. Partnership between social services and medical/health services (human services)
26. Seamless provision of care across international, national, provincial, and cultural borders
27. Accountability
28. Acceptance of pluralistic models of health and healing
29. Democratizing access to information and technology
30. Freedom of choice among system participants

Group B: Engage the Underserved and Vulnerable to Change the System

Albenita Correia
Brazil

The group identified vulnerable populations in each of their countries. Many vulnerable populations are the same, others are different. In all countries, for example, health inequities correlate with economic status. Poor people get inadequate, inferior health care. Other vulnerable populations include the elderly, undocumented immigrants, refugees, adolescents, HIV victims, mentally disturbed, as well as socially isolated families and rural populations.

Michael DeLucia
USA

They also face barriers to getting quality care. The group identified five types of barriers: cultural, resource-based, geographic, legal and political, and those which are functional or structural in nature. For example, cultural barriers include religion, gender, and behavior. Others embrace human rights, lack of eligibility for health care insurance, and the impact of managed heath care.

The group suggested multiple strategies for engaging the underserved in helping to change the system. The poor must actually be empowered by such approaches as those described in the Haiti and Detroit presentations.

Anil Dhar
India

Having hard facts about health inequities is also important. The result is the ability to think about social marketing strategies, or how to bring about change by conveying the scope of problems and potential change. The group also said that for many countries, the best approach is to work toward universal coverage by means of an affordable, universal health-insurance model. In seeking that goal, the group outlined a set of strategic considerations, including:

- Always begin with the community.
- The community must own the intervention.
- Incorporate experts but don't let them take over the process.
- Tap into existing leadership structures.
- Assess programs and build on them.
- Facilitate leadership development.
- Build advocacy capacity internal to the group.
- Collaborate with existing health-service systems.
- Empower the community.

Saleh El-Qaderi
Jordan

Armen Gasparyan
Armenia

Christiane Grimm
Germany

Rouzanne Gyurjyan
Armenia

Sunday Idemudia
Nigeria

Group C: Identify Decisionmakers and Strategies to Build Consensus

This group went through a process of defining health care, access, and strategies. It suggested there are usually at least 18 stakeholders in establishing an equitable health care system. The five most important stakeholders are consumers (patients and clients), health providers, the communities, educators and research institutions, as well as political officials. Others include labor unions, health-insurance providers, philanthropists, and international agencies.

Strategies are necessary in order to build consensus, and that happens only when stakeholders consider the socioeconomic characteristics of their community, the political power structure and will, and the resources available for their effort.

The group illustrated the process necessary to strategically involve stakeholders at various levels and stages in order to achieve a real paradigm change in a health care system. Teamwork is essential, and developing written partnership agreements can also be critical to success.

Strategies to Build Consensus

Group C Felt that Stakeholders Must:

- Define common vision, mission, objectives
- Conduct strategic planning to include deliverables, indicators, and outcomes/results
- Test and implement their plans
- Monitor and evaluate their activities (with the use of the indictors)
- Conduct feedback/dissemination of the results of the evaluation

Group D: Safeguard Community Health and Guarantee Quality of Care

How does a community or a country safeguard this "ideal health care system," once it has been established around the definition, goals, strategies, and outcomes described by the other seminar groups?

Group D expressed the view that the government, at all levels, has the overriding responsibility for safeguarding the community's health. And individual citizens, the community as a whole, and health care providers should hold the government accountable.

"The building blocks for ensuring such safeguards can be the government's constitution, which is the case in a number of countries, and the judicial system. This responsibility needs to be translated then into health care services, which are supported by local, regional, and national budgets," the group reported.

These safeguarding responsibilities and tasks must be continually evaluated through process and outcome strategies, the group added, as well as technological and political strategies that transform data into health policy and action.

Boyko Ivanov
Bulgaria

Pilar Jiminez
Philippines

Qu Jingdong
China

Jeanette Taylor Jones
USA

Beatrice Khoza
South Africa

Nomaswazi Khoza
South Africa

Svetlana Kichtchenko
Russia

Maylene Shung King
South Africa

Manal Koura
Egypt

"As long as users do not have choices, and the knowledge, skills, and tools to assess the quality of care, it is unlikely to expect a change in service provision."

– Alvaro de Romaña

Barbara Krimgold
USA

Shanthi Krishnaraj
India

Gulnara Kuzibaeva
Uzbekistan

Arunas Lukosevicius
Lithuania

Mary Helen Mays
USA

Fernando Mazza
Argentina

Emmanuel Obeng
Ghana

Jegede Ademola Oluborode
Nigeria

Anthony Onipede
Nigeria

"The real challenge is translating values into real, concrete policies that change the health system. It won't take care of itself."

– Timothy Evans

Candy Altuna Pastor
Peru

Tara Pokhrel
Nepal

Dean Robinson
USA

Alvaro de Romaña
Peru

Jacek Ruszkowski
Poland

Danica Salaski
Yugoslavia

Mauricio Serra
Colombia

Mary Simpson
USA

Lucille Smith
USA

Herbert Smitherman
USA

Eveline Thevenard
France

Lora Todorova
Bulgaria

Sohalia Umair
Pakistan

Alejandro Varela
Colombia

Susanna Helfer Vogel
Colombia

Jeri Veenstra
USA

Edith Wolff
USA

Zarin Zain
Malaysia

Abbas Zezai
Zimbabwe

Gazmend Zhuri
Kosovo

Faculty

Vernice Davis ANTHONY (Co-Chair) is senior vice president of Corporate Affairs and Community Health at St. John Health System, Detroit, Michigan. Ms. Anthony is credited with developing a model for Integrated Health Systems Community Health Status Improvement, providing leadership for the Detroit Health System's Collaborative, establishing the Michigan Task Force on Violence Reduction and Prevention, and the Michigan Abstinence Partnership. Prior to this, she served as director of the Michigan Department of Public Health. Ms. Anthony serves on many boards and commissions including the Immunization Safety Review Committee of the Institute of Medicine, the Michigan Department of Community Health – Health Plans Advisory Council, the Board of Governors of Wayne State University, and is chairperson of the Center for Health Promotion. She has received numerous awards including the University of Michigan School of Public Health Distinguished Alumni Award and the Anti-Defamation League's Women of Achievement Award 1999. Ms. Anthony received a master's degree in public health from the University of Michigan.

Ligia DE SALAZAR (Co-Chair) is director of the Research Evaluation Center in Public Health (CEDETES) at the School of Public Health, Universidad del Valle, Cali, Colombia. Her research experience and interests include the process and cost-effectiveness evaluation of public health policies, programs, and interventions; models to build healthy communities and municipalities; the implementation and evaluation of models to improve the access and quality of health care in rural and urban areas; and community participation in the delivery of health care, with a focus on auditing, advocacy, and negotiation. From 1993 to 1994, Dr. de Salazar served as a program director of Partnership for Child Development, a project coordinated by Oxford University, United Kingdom. Prior to this, she was a consultant for the World Health Organization in Geneva and Tanzania. For two years, Dr. de Salazar was the UNICEF (United Nations Children's Fund) permanent consultant on primary health care. She received a Ph.D. in evaluation from McGill University, Montreal, Canada.

Orvill B. R. ADAMS is director of the Department of Health Service Provision at the World Health Organization in Geneva, Switzerland. His activities include the management of the Department in order to contribute to the improved health system performance through analysis, tracking, and advising on the most effective approaches for affordable quality service provision; helping member states to analyze access to, coverage, and utilization of critical health interventions at the community level; and providing evidence-based policy guidance on human resources development. From 1995 to 1999, Mr. Adams served as a scientist in the Human Resources for Health Division of the World Health Organization. In this role, he assisted countries in human resources management, skill mix, the development of health performance indicators, and policy and management approaches to the improvement of human resources development. Prior to this, he was principal in his own company, Curry, Adams & Associates, Inc., committed to the development and practice of effective and efficient management in public and private health. Mr. Adams serves on the Advisory Committee on the Impact of Technological Change on Human Resource in Health Care. He received an M.A. in international affairs from Carleton University, Ottawa, Ontario, and an M.A. in economics from the University of Ottawa, Ontario.

Mesfin ADDISSE is head of the Department of Community Health at Gondar College of Medical Sciences in Ethiopia. Dr. Addisse serves as senior research supervisor for medical and health officer students. His own research interests include the perpetuation of leprosy stigma in Ethiopia and its eradication, and teachers' and parents' attitudes towards sex education in schools. Dr. Addisse currently teaches courses on the epidemiology of infectious diseases, maternal and child health, and medical ethics. Prior to this, he was head of the Regional Health Bureau in Afar Regional State. He was a consultant for numerous projects including the McGill Community Health Project that focused on the children of leprosy patients, the Afar Relief and Development Organization, and Afar Aid. Dr. Addisse is chair of the Community Health Department at Gondar College of Medical Sciences, and chair of the regional steering committee for advanced training in primary health care. He is a member of the Ethiopian Public Health Association. Dr. Addisse holds an M.D. from Addis Ababa University.

Ricardo H. Dios ALEMÁN is the total quality management consultant at Pathfinder International for Project 2000, Peruvian Ministry of Health, Lima, Peru. Dr. Alemán leads the design and implementation of strategies for improving local and regional quality management teams. Concurrently, he works for Health Services Development where he is responsible for the development of an innovative model for health services, which includes an integrated approach to family health problems and risks, and a strategy for community-based health surveillance. From 1995 to 1999, Dr. Alemán served as regional adviser to CARE Peru and the Pan-American Health Organization. In this position, he provided technical assistance to regional health directorates for the design, implementation, monitoring, and evaluation of the Continuous Quality Improvement Process. Prior to this, Dr. Alemán was regional director for the Ministry of Health where he introduced innovative procedures for the planning, development, and evaluation of health programs. Dr. Alemán graduated as a medical doctor from the Universidad Nacional de Trujillo, Peru.

Erve BOTTEX is HIV/AIDS Family Services Coordinator for Volunteers of America, New York, USA. His work involves advocacy for HIV/AIDS-infected and -affected families, and the representation of clients in obtaining and maintaining social and financial benefits. Dr. Bottex is currently completing a master of public health degree at New York Medical College, Valhalla, New York. From 1993 to 1996, Dr. Bottex served as the community health director in rural Haiti at the Albert Schweitzer Hospital in Deschapelles. He was responsible for a community-based program promoting rural health care and social development. He has conducted community-based intervention in malnutrition rehabilitation, and observed, trained, and directly supervised tuberculosis therapy. Dr. Bottex served as the project manager for the Maternal and Child Health Program at the Christian Mission of Pignon, where he trained health workers in managing maternal and child health as well as family planning. He received a diploma in tropical medicine and public health from the Swiss Tropical Institute in Basel, Switzerland, and an M.D. from Haiti State University, Port-au-Prince. Dr. Bottex served as a faculty member at Salzburg Seminar Session 334, Health Care Partnerships: Meeting the Needs of Underserved Communities, 1996.

"Financing systems could be explicitly stated to demonstrate how programs can be initiated and succeed."

–Jeri Veenstra

Timothy G. EVANS is director of Health Equity at the Rockefeller Foundation, New York. He is responsible for the development and implementation of program strategy aimed at redressing disparities in health. Dr. Evans' work has involved the transformation of the Children's Vaccine Initiative to the Global Alliance for Vaccines and Immunization, a new effort on reducing barriers to access to medicines, the rethinking of public health training and research policy in developing countries, and clinical trials to simplify AIDS treatment protocols. From 1995 to 1998, he served as assistant professor of international health economics at the Harvard School of Public Health, Boston, Massachusetts. Dr. Evans taught and researched the broader determinants of health, the measurement of health status, equity in health, and assessing the impact of chronic diseases. He has received numerous awards including a MacArthur Fellowship at the Harvard School of Public Health, and an International Exchange of Experts in Rehabilitation Fellowship. Dr. Evans is a founding board member of the Global Forum for Health Research, and a member of the Scientific Peer Review Group of the World Health Organization's Health System Performance Appraisal. He received an M.D. from MacArthur University, Canada, and a D.Phil. in agricultural economics from the University of Oxford, United Kingdom.

Yan GUO is professor and vice dean of the School of Public Health at Peking University, People's Republic of China. Professor Guo's research interests include health equity, the management of poverty alleviation, and the reproductive needs of adolescents in China. From 1992 to 1997, she served as associate professor at the Training Center for Health Management, School of Public Health, Beijing Medical University. Professor Guo worked as a consultant for numerous international projects including the Women and Reproductive Health and Micro Nutrition Project supported by the World Food Program; the Qinba Poverty Alleviation Project, sponsored by the World Bank; and UNICEF's Middle-Term Review of Health and Nutrition Project. Between 1992 and 1997, she managed a variety of projects that focused on the evaluation of primary health care in rural areas of China. Professor Guo received an M.D. from Beijing Medical University, and an MPH from Tulane University, New Orleans, Louisiana, USA.

David R. WILLIAMS is professor of sociology, a senior research scientist at the Institute for Social Research, and a faculty associate in the African American Mental Health Research Center and the Center for Afroamerican and African Studies at the University of Michigan, Ann Arbor. His research focuses on the social influences on health and the trends and determinants of socioeconomic and racial differences in mental and physical health. Dr. Williams is the principal investigator of a national study of the effects of forgiveness on health in the United States, and a study of the effects of torture on mental health in South Africa. From 1992 to 1998, he was associate professor of sociology at Yale University, New Haven, Connecticut. Dr. Williams is a member of the Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care and the MacArthur Foundation's Research Network on Socioeconomic Status and Health. He has received numerous awards, including an Investigator Award in Health Policy Research from The Robert Wood Johnson Foundation. Dr. Williams holds a Ph.D. in sociology from the University of Michigan.

"Change is all about building relationships and how you work with people."

– Maylene Shung King

Session Coordinators

Marguerite M. JOHNSON is vice president for programs, health, at the W.K. Kellogg Foundation, Battle Creek, Michigan. She is responsible for overseeing program development and administration as well as program/project evaluation and dissemination in health grantmaking. Prior to joining the Foundation, Ms. Johnson was vice president of programs at the Rose Community Foundation in Denver, Colorado. As one of the first staff members to be hired, she was instrumental in establishing the organization's grantmaking strategies, policies, and procedures. Before that, she was a senior program officer at The Robert Wood Johnson Foundation in Princeton, New Jersey. In addition, Ms. Johnson's work as a community health professional has included high-risk prenatal program coordinator at the Colorado Department of Public Health in Denver; community health planner at Framington Union Hospital in Massachusetts; and adolescent program director at the Roxbury Comprehensive Community Health Center in Boston, Massachusetts. She has served as a board member of numerous nonprofit organizations including the

Colorado Association of Nonprofit Organizations. Ms. Johnson holds a master's degree in social services from Bryn Mawr College, Graduate School of Social Work, Pennsylvania, and a master's of science degree in health policy and management from Harvard University School of Public Health, Boston, Massachusetts.

Henrie M. TREADWELL is a program director for health at the W.K. Kellogg Foundation, Battle Creek, Michigan. Her major responsibilities include program design and oversight, and administration of strategic initiatives to improve access to health coverage and services. Dr. Treadwell is also responsible for development of leadership-development programs that improve the potential for program sustainability and policy option formulation. Her current key activities include the management of Community Voices, a major investment in community access to health services; management of multiple predoctoral and postdoctoral programs that support the development of a culturally diverse leadership cadre; and the development of policy briefs that selectively inform policy and practice on the local, state, and national level. Prior to this appointment, Dr. Treadwell was chair of the Division of Mathematics and Natural Sciences at Morris Brown College, Atlanta, Georgia. She has served as consultant to many national organizations including the National Science Foundation and the National Institutes of Health. She holds a Ph.D. in biochemistry and molecular biology from Atlanta University, Georgia. Dr. Treadwell served as a faculty member at Salzburg Seminar Session 334, Health Care Partnerships: Meeting the Needs of Underserved Communities, 1996.

"Sometimes health care improvements can take place in spite of the government. We have been able to do that in Pakistan, in several cases funded by local businesses."

– Sohalia Umair

Fellows

Argentina
Fernando Mazza

Armenia
Armen Gasparyan
Rouzanne Gyurjyan

Brazil
Paulo Capucci
Albenita Correia

Bulgaria
Boyko Ivanov
Lora Todorova

China
Qu Jingdong

Colombia
Esmeralda Burbano
Susanna Helfer Vogel
Mauricio Serra
Alejandro Varela

Egypt
Manal Koura

France
Eveline Thevenard

Germany
Christiane Grimm

Ghana
Emmanuel Obeng

India
Anil Dhar
Shanthi Krishnaraj

Jordan
Saleh El-Qaderi

Kosovo
Gazmend Zhuri

Kyrgyzstan
Damira Bibosunova

Lithuania
Arunas Lukosevicius

Malaysia
Zarin Zain

Nepal
Tara Pokhrel

Nigeria
Sunday Idemudia
Jegede Ademola Oluborode
Anthony Onipede

Pakistan
Sohalia Umair

Peru
Candy Altuna Pastor
Bruno Benavides
Alvaro de Romaña
Jerry Rebaza Campos

Philippines
Pilar Jiminez

Poland
Jacek Ruszkowski

Russia
Svetlana Kichtchenko

South Africa
Beatrice Khoza
Nomaswazi Khoza
Maylene Shung King

Turkey
Yusuf Celik

USA
Carlotta Arthur
John Baldwin
Diane Calleson
Dionne Colbert
Mae Tomiko Conner
Michael DeLucia
Jeanette Taylor Jones
Barbara Krimgold
Mary Helen Mays
Dean Robinson
Mary Simpson
Lucille Smith
Herbert Smitherman
Jeri Veenstra
Edith Wolff

Uzbekistan
Gulnara Kuzibaeva

Yugoslavia
Danica Salaski

Zimbabwe
Abbas Zezai

Salzburg Seminar Library

Session 395

Improving Access to Health Care and Human Services: Elements of Success

March 6 – 13, 2002

Final Bibliography

The following books and papers were on the Reserve Shelf in the library for use during this session. The bibliography includes the ISBN (International Standard Book Number).

Books and Reports

Aday, Lu Ann. At Risk in America. *The Health and Health Care Needs of Vulnerable Populations in the United States.* San Francisco, CA: Jossey Bass Publishers, 1993. ISBN: 1-55542-503-8. (362.1 ADA)

Aparatjita. Relief and Long Term Rehabilitation for Cyclone-Affected People of Orissa. New Delhi, India: Voluntary Health Association of India, September 2000.

Beauchamp, Dan E., and Bonnie Steinbock, eds. *New Ethics for the Public's Health*. New York, NY: Oxford University Press, 1999. ISBN: 0-19-512439-1. (174 NEW)

Bracht, Neil, ed. *Health Promotion at the Community Level.* Newbury Park, CA: SAGE Publications, 1990. ISBN: 0-8039-3858-6. (362.1 HEA)

Brennan, Troyen A., and Donald M. Berwick. *New Rules: Regulation, Markets, and the Quality of American Health Care*. San Francisco, CA: Jossey- Bass Publishers, 1995. ISBN: 0-7879-0149-0. (362.1 BRE)

Butler, John. *The Ethics of Healthcare Rationing: Principles and Practices.* London and New York: Cassell, 1999. ISBN: 0-304-70581-0. (362.1 BUT)

Challenging Inequities in Health. From Ethics to Action. Summary. New York, NY: The Rockefeller Foundation. ISBN: 0-89184-054-0.

Children in South Africa. Their Right to Health. Child Health Policy Institute, Child Health Unit, University of Cape Town, South Africa. September 1999.

Coreil, Jeannine, Carol A. Bryant, and J. Neil Henderson. *Social and Behavioral Foundations of Public Health*. Thousand Oaks, CA: Sage Publications, 2001. ISBN: 0-7619-1744-6. (362.1 COR)

Dranove, David. *The Economic Evolution of American Health Care: From Marcus Welby to Managed Care*. Princeton and Oxford, MA: Princeton University Press, 2000. ISBN: 0-691-06693-8. (338.4 DRA)

Evans, Robert G., Morris L. Barer, and Theodore R. Marmor, eds. *Why Are Some People Healthy and Others Not?: The Determinants of Health of Populations*. New York, NY: Aldine de Gruyter, 1994. ISBN: 0-202-30490-6. (614.4 WHY)

Evans, Timothy, et al., eds. *Challenging Inequities in Health. From Ethics to Action*. Oxford, UK, and New York, NY: Oxford University Press, 2001. ISBN: 0-19-513740-X. (362.1 CHA).

Farmer, Paul. *Infections and Inequalities: The Modern Plagues*. Berkeley, CA: University of California Press, 1999. ISBN: 0-520-21544-3. (306.4 FAR)

Fuchs, Victor R. *The Future of Health Policy*. Cambridge, MA: Harvard University Press, 1993. ISBN: 0-674-33825-1. (362.1 FUC)

Garrett, Laurie. *Betrayal of Trust: The Collapse of Global Public Health*. New York, NY: Hyperion, 2000. ISBN: 0-7868-6522-9. (362.1 GAR)

Gleason, Herbert P., ed. *Getting Better: A Report on Health Care from the Salzburg Seminar*. Cambridge, MA: Oelgeschlager, Gunn & Hain Publishers, Inc., 1981. ISBN: 0-89946-053-4. (362.1 GLE)

Health at a Glance. Paris, France: Organization for Economic Co-Operation and Development, 2001. (362.1 HEA)

Health Care Partnerships: Meeting the Needs of Underserved Communities Around the World. Item #481, Battle Creek, MI: W.K. Kellogg Foundation, 1997. (362 HEA)

Hernandez, Donald J. *Children of Immigrants: Health, Adjustment, and Public Assistance*. Washington, DC: National Academy Press, 1999. ISBN: 0-309-06545-3. (362.7 CHI)

Herzlinger, Regina. *Market Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry*. Cambridge, MA: Pursues Books, 1997. ISBN: 0-7382-0136-7. (362.1 HER)

Hirshowitz, Ros and Mark Orkin. *A National Household Survey of Health Inequalities in South Africa*. CASE survey for Henry J. Kaiser Family Foundation, 1995. ISBN: 0-944525-23-7. (362.1 HIR)

Hogue, Carol J. R., Martha A. Hargraves, and Karen Scott Collins, eds. *Minority Health in America: Findings and Policy Implications from the Commonwealth Fund Minority Health Survey*. Baltimore, MA: The Johns Hopkins University Press, 2000. ISBN: 0-8018-62-99-X. (362.1 MIN)

Human Development Report 2000. New York, NY: Oxford University Press for the United Nations Development Programme (UNDP), 2000. ISBN: 0-19-521678-4. (REF 306.3 HUM 2000)

Investment in Health: Social and Economic Returns. Scientific and Technical Publication No. 582, Washington, DC: Pan American Health Organization, 2001. (362.1 INV)

Kawachi, Ichiro, Bruce P. Kennedy, and Richard G. Wilkinson, eds. *The Society and Population Health Reader*. Vol. I. New York, NY: The New Press, 1999. ISBN: 1-56584-526-9. (362.1 SOC)

Kim, Jim Yong, et al., eds. *Dying for Growth: Global Inequality and the Health of the Poor*. Monroe, ME: Common Courage Press, 2000. ISBN: 1-56751-160-0. (362.1 DYI)

Koop, C. Everett, et al., eds. *Critical Issues in Global Health*. San Francisco, CA: Jossey-Bass, 2001. ISBN: 0-7879-4826-1. (362.1 CRI)

Kozol, Jonathan. *Amazing Grace: The Lives of Children and the Conscience of a Nation*. New York, NY: Crown Publishers, Inc., 1995. ISBN: 0-517-799999-5. (362.7 KOZ.)

Levin, Lowell S., Laurie McMahon, and Erio Ziglio, eds. *Economic Change, Social Welfare, and Health in Europe*. WHO Regional Publications, European Series, No. 54. Copenhagen, Denmark: WHO, 1994. ISBN: 92-890-1318-4. (306.4 ECO)

Macroeconomics and Health: Investing in Health for Economic Development. Report from the chair of the Commission on Macroeconomics and Health, World Health Organization. 20 December 2001. Report available on the Internet: http://www3.who.int/whosis/cmh/cmh_report/e/report.cfm?path=cmh,cmh_ report (362.1 MAC)

Mann, Jonathan M., et al. *Health and Human Rights.* New York, NY: Routledge, 1999. ISBN: 0-415-92102-3. (174 HEA)

Marmot, Michael, and Richard G. Wilkinson, eds. *Social Determinants of Health*. Oxford, UK: Oxford University Press, 1999. ISBN: 0-19-263069-5. (302.1 SOC)

Martin, Linda G., and Beth J. Soldo, eds. *Racial and Ethnic Differences in the Health of Older Americans.* Washington, DC: National Academy Press, 1997. ISBN: 0-309-05489-3. (613 RAC)

McIntyre, Di, et al. *Health Expenditure and Finance in South Africa*. Cape Town, South Africa: Health Systems Trust and the World Bank, 1995. ISBN: 0-9584027-2-8. (362.1 HEA)

McKnight, John. *The Careless Society: Community and Its Counterfeits*. New York, NY: Basic Books, 1995. ISBN: 0-465-09125-3. (361.973 MCK)

Nordberg, Erik, and David Finer, eds. *Society, Environment, and Health in Low-Income Countries*. Stockholm, Sweden: Karolinska Institutet, Department of International Health Care Research (IHCAR), 1990. ISBN: 91-85910-54-6. (363.7 SOC)

Report of the Independent Commission on Health in India. New Delhi, India. Voluntary Health Association of India, 1997.

Rich, John A. and Marguerite Ro. *A Poor Man's Plight: Uncovering the Disparity in Men's Health.* Item #476. Battle Creek, MI: W.K. Kellogg Foundation, February 2002.

A Search for Innovations and Sustainability in Community Health and Development. New Delhi, IN. Voluntary Health Association of India, 2001.

Stein, Ruth E.K., ed. *Health Care for Children: What's Right, What's Wrong, What's Next.* New York, NY: United Hospital Fund of New York, 1997. ISBN: 1-881277-31-3.

Tauber, Alfred I. *Confessions of a Medicine Man: An Essay in Popular Philosophy*. Cambridge, MA: The MIT Press, 1999. ISBN: 0-262-20114-3. (174 TAU)

Wallace, Deborah and Rodrick Wallace. *A Plague on Your House: How New York Burned Down and National Public Health Crumbled*. London and New York: Verso, 1998. ISBN: 1-85984-858-3. (362.1 WAL)

What Communities Value About Health and Health Care. Item #477. Battle Creek, MI: W.K. Kellogg Foundation, September 2001.

Wilkinson, Richard G. *Unhealthy Societies: The Afflictions of Inequality*. London and New York: Routledge, 1996. ISBN: 0-415-09235-3. (306.4 WIL)

World Health Organization. Health21: The Health for All Policy Framework for the WHO European Region. Copenhagen, Denmark: WHO Regional Office for Europe, 1999. ISBN 92-890-1349-47. (362.1 HEA)

The World Health Report 1999. Making a Difference. Geneva, Switzerland: World Health Organization, 1999. ISBN: 92-4-156194-7. (REF 362.1 WOR)

Zipperer, Lorri A. and Brian P. Pace, eds. *Healthcare: Resource and Reference Guide*. Chicago, IL: American Medical Association, 1993. ISBN: 0-89970-5545. (REF 362.1 HEA)

Articles and Journals

Baker, Peter. "The International Men's Health Movement." *BMJ* 323, November 3, 2001, 1014 - 1015. Available on the Internet: <http://bmj.com/cgi/content/full/323/7320/1014?eaf>

Banks, Ian. "No Man's Land: Men, Illness, and the NHS." BMJ 323, November 3, 2001, 1058 - 1060. Available on the Internet: <http://bmj.com/cgi/content/full/323/7320/1058?eaf>

Barach, Paul and Fiona Moss. "Delivering Safe Health Care." BMJ 323, September 15, 2001, 585 – 586. Available on the Internet: <http://bmj.com/cgi/reprint/323/7313/585.pdf>

Bennett, D. L. and E. Eisenstein. "Adolescent Health in a Globalised World: A Picture of Health Inequalities." Adolescent Medicine: State of the Art Reviews, Vol. 12, No. 3, October 2001, 411 – 426.

Bushby, Kate, Simon Raybould, Sara O'Donnell, and James G. Steele. "Social Deprivation in Duchenne Muscular Dystrophy: Population Based Study." BMJ 323, November 3, 2001, 1035 - 1036. Available on the Internet: <http://bmj.com/cgi/content/full/323/7320/1035?eaf>

"Critical Issues in Health System Performance Assessment. Regional Consultation on Health System Performance Assessment." WHO, 8 – 10 May 2001. Available on the Internet: <http://www.fiocruz.br/cict/dis/vering.htm>

Doyal, Lesley. "Sex, Gender, and Health: The Need for a New Approach." BMJ 323, November 3, 2001, 1061 - 1063. Available on the Internet: <http://bmj.com/cgi/content/full/323/7320/1061?eaf>

"Dying for Change. Poor People's Experience of Health and Ill-Health." World Health Organization and World Bank, January 2002. Available on the Internet: <http://www.worldbank.org/poverty/voices/reports/dying/dyifull.pdf>

Fonn, Sharon and Khin San Tint. "Transforming Reproductive Health Services in South Africa: Women's Health Advocates and Government in Partnership." Unpublished Paper, Johannesburg, ZA.

Fraser, Sarah F. and Trisha Greenhalgh. "Coping with Complexity: Educating for Capability." BMJ 323, October 6, 2001, 799 - 803. Available on the Internet: <http://bmj.com/cgi/reprint/323/7316/799.pdf>

"General Report on the Regional Consultative Meeting on Health Systems Performance Assessment. Concerns and Recommendation Related to Institutional Goals and Performance Index Measurement." WHO. 18 – 20 July, 2001. Available on the Internet: <http://www.who.int/health-systems-performance/regional_consultations/afro_report.pdf>

Geronimus, Arline T. "Understanding and Eliminating Racial Inequalities in Women's Health in the United States: The Role of Weathering Conceptual Framework." JAMWA, Vol. 56, 2001, 133 – 136.

Gilbert, M. Jean. "We Have Come a Long Way: Women's Health at the Turn of the Millennium." Permanente Journal, Vol. 4, No. 3, Summer 2000. Available on the Internet:<http://www.kp.org/medicine/permjournal/sum00pj/millenium.html>

Gwatkin, Davidson R. "Overcoming the Inverse Care Law: Designing Health Programs to Serve Disadvantaged Population Groups in Developing Countries." Initial Discussion Draft, November 2001.

"Health for the Millions. Revised National Health Policy." New Delhi, IN. Voluntary Health Association of India. Vol. 27, No. 5 & 6, September–December 2001.

Hertzman, Clyde. "Health and Human Society." American Scientist, Vol. 89, No. 6, Nov/Dec 2001, 538 – 545.

Hogan, Vijaya K., et al., eds. "A Public Health Framework for Addressing Black and White Disparities in Preterm Delivery." JAMWA, Vol. 56, 2001, 177 – 180.

House, James S. and David R. Williams. "Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health." In: Promoting Health: Intervention Strategies from Social and Behavioral Research. Washington, DC. National Academy Press, 2000, 81 – 124.

"In the Middle: A Report on Multicultural Boomers Coping With Family and Aging Issues." AARP Research Center. Available on the Internet: <http://research://www.aarp.org/il/in_the_middle.html>

Journal of the American Medical Women's Association (JAMWA). Special Issue: "Disparities in Women's Health", Vol. 56, No. 4, Fall 2001. Available on the Internet: <http://jamwa.amwa-doc.org/vol56/toc56_4.htm>

Katz, Barry P., et al. "Demographic Variation in the Rate of Knee Replacement: A Multi-Year Analysis." Health Services Research, Vol. 31, No. 2, June 1996, 126 – 140. Available on the Internet: <http://www.hsr.org/pdf/31125.pdf>

Kiss, Alexander and Siegfried Meryn. "Effect of Sex and Gender on Psychosocial Aspects of Prostate and Breast Cancer." BMJ 323, November 3, 2001, 1055 – 1058. Available on the Internet: <http://bmj.com/cgi/content/full/323/7320/1055?eaf>

"Mapping a Global Pandemic: Review of Current Literature on Rape, Sexual Assault, and Sexual Harassment of Women. Consultation on Sexual Violence Against Women." Global Forum for Health Research. Available on the Internet: <http://www.globalforumhealth.org/Non_compliant_pages/vaw/litrevmain.html>

Mathers, Colin D., et al. "Healthy Life Expectancy in 191 Countries." The Lancet Vol. 357, No. 9269, 2001, 1685 – 1691.

McKee, Martin and Vladimir Shkolnikov. "Understanding the Toll of Premature Death Among Men in Eastern Europe." BMJ 323, November 3, 2001, 1051 – 1055. Available on the Internet: <http://bmj.com/cgi/content/full/323/7320/1051?eaf>

"Men Aging and Health. Achieving Health Across the Life Span." Geneva, Switzerland. World Health Organization, 2001.

Meryn, Siegfried and Alejandro R. Jahad. "The Future of Men and Their Health. Are Men in Danger of Extinction?" BMJ 323, November 3, 2001, 1013 – 1014. Available on the Internet: <http://bmj.com/cgi/content/full/323/7320/1013?eaf>

Mittelmark, Maurice B. "Promoting Social Responsibility for Health: Health Impact Assessment and Healthy Public Policy at the Community Level." Health Promotion International, Vol. 16, No. 3, September 2001, 260 – 274. Available on the Internet: <http://www.heapro.oupjournals.org/cgi/reprint/16(3/269.pdf>

Model of Utilization." Health Services Research, Vol. 33, No. 3, August 1998, 571 – 596. Available on the Internet: <http://www.hsr.org/pdf/33571.pdf>

"Module 2: Social Determinants." WHO Training Curriculum: Gender and Rights in Reproductive Health.

Pearson, Mark. "How Can the Allocation of Public Resources for Health be Made More Pro-Poor?" DFID-Health Systems Resource Centre, 2001. Available on the Internet: <http://www.healthsystemsrc.org/Pdfs/Res_alloc.pdf>

Phillips, Kathryn A., et al. "Understanding the Context of Healthcare Utilization: Assessing Environmental and Provider-Related Variables in the Behavioral Model of Utilization." Health Services Research Vol. 33, No. 3, August 1998, 571-596.

Plsek, Paul E. and Tim Wilson. "Complexity, Leadership, and Management in Healthcare Organizations." BMJ 323, September 29, 2001, 746 – 749. Available on the Internet: <http://bmj.com/cgi/reprint/323/7315/746.pdf>

Plsek, Paul E. and Trisha Greenhalgh. "The Challenge of Complexity in Health Care." BMJ 323, September 15, 2001, 625 – 628. Available on the Internet: <http://bmj.com/cgi/reprint/323/7313/625.pdf>

"Report on WHO Technical Consultation on the Measurement of Health Inequalities." WHO, Draft Paper, November 7 – 8, 2001. Available on the Internet: <http://www.who.int/health-systems-performance/technical_consultations/inequalities_report.pdf>

"A Research and Development Strategy for Public Health." Department of Health, April 2001. Available on the Internet: <http://www.doh.gov.uk/research/documents/randdpublichealth.pdf>

Sen, Amartya. "Many Faces of Gender Inequality." Frontline, Vol. 18, No. 22, Oct. 27 – Nov. 9, 2001. Available on the Internet: <http://www.hinduonnet.com/fline/fl1822/18220040.htm>

Sims, Trista N., Ralph Bangs, and Ken Thompson, eds. "Health Problems Among African American Women Age 35-64 in Allegheny County." A Black Paper for the Urban League of Pittsburgh. September 2001.

Wagstaff, Adam. "Inequality Aversion, Health Inequalities, and Health Achievement." Development Research Group and Human Development Network, World Bank, Washington, DC, USA and School of Social Sciences, University of Sussex, Brighton, UK. January 2002.

Williams, David R. and Toni D. Rucker. "Understanding and Addressing Racial Disparities in Health Care." Health Care Financing Review, Vol. 21, No. 4, Summer 2000, 75 – 90.

Wilson, Tim and Tim Holt. "Complexity and Clinical Care." BMJ 323, September 22, 2001, 685 – 688. Available on the Internet: <http://bmj.com/cgi/reprint/323/7314/685.pdf>

Relevant Web Sites

- Global Forum for Health Research <http://www.globalforumhealth.org>
- International Society for Men's Health <http://www.ismh.org>
- Kaiser Family Foundation <http://www.kff.org>
- PAHO equity listserv <http://www.paho.org/English/HDP/equidad-list-about.htm>
- Rockefeller Foundation <www.rockfound.org>
- Turning Point: Collaborating for a New Century in Public Health <http://www.naccho.org/project30.cfm>
- UK Health Equity Network <http://www.ukhen.org.uk>
- The Urban Institute <http://www.urban.org>
- The Verona Initiative <http://www.who.dk/Verona/main.htm>
- W.K. Kellogg Foundation <http://www.wkkf.org>
- W.K. Kellogg Foundation's Community Voices Initiative <http://www.communityvoices.org>

SALZBURG SEMINAR 395

W.K. KELLOGG FOUNDATION

HE4054
Item #545
0103 2M SPA
Printed on Recycled Paper